DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-05

2. STATE: Nevada

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 752,494
b. FFY 2005 $1,567,013

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 1b, 2, 2a and 4a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 1b, 2, 2a and 4a

10. SUBJECT OF AMENDMENT:
CPT Medicine Codes Pediatric Enhancement

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, DHR

15. DATE SUBMITTED: APR - 7 2004

16. RETURN TO:

John A. Liveratti, Chief
Compliance, DHCFP
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 7, 2004

18. DATE APPROVED: September 24, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Pat Dalley for Linda Minamoto

21. TYPED NAME:
Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

5. Payments for services billed by physicians using Current Procedural Terminology (CPT) codes will be calculated using the April 1, 2002 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2002 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
   a. Surgical codes 10000-58999 and 60000-69999 will be reimbursed at 100% of the Medicare facility rate.
   b. Radiology codes 70000-79999 will be reimbursed at 100% of the Medicare facility rate.
   c. Medicine codes 90000-99199 and 99500-99999 and Evaluation and Management codes 99201-99999 will be reimbursed at 85% of the Medicare non-facility rate.
   d. Obstetrical services classified under CPT codes 59000-59999 will be reimbursed at 128% of the Medicare non-facility rate.
   e. Anesthesia services will be reimbursed at a fixed fee per unit value of the 1974 CRVS as modified.

6. Medical care and any other type of remedial care provided by licensed practitioners:
   a. Payment for services billed by a Podiatrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
      1. Surgical codes 10000-58999 and 60000-69999 will be reimbursed at 74% of the Medicare facility rate
      2. Radiology codes 70000-79999 will be reimbursed at 88% of the Medicare facility rate
      3. Medicine codes 90000-99199 and 99500-99999 and Evaluation and Management codes 99201-99999 will be reimbursed at 66% of the Medicare non-facility rate.
   b. Payment for services billed by an Optometrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or 85% of the Medicare non-facility rate. See also 12.d.,
   c. Payment for services billed by a Chiropractor will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
      1. Medicine codes 90000-99199 and 99500-99999 and Evaluation and Management codes 99201-99999 will be reimbursed at 70% of the Medicare non-facility rate
      2. Radiology codes 70000-79999 will be reimbursed at 32% of the Medicare facility rate.

d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife/Nurse Anesthetist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Surgical codes 10000-58999 and 60000-69999 will be reimbursed at 69% of the Medicare facility rate
2. Medicine codes 90000-99199 and 99500-99999 and Evaluation and Management codes 99201-99999 will be reimbursed at 74% of the Medicare non-facility rate.
3. Anesthesia services will be reimbursed at a fixed fee per unit value of the 1974 CRVS as modified.
4. Obstetrical services classified under CPT codes 59000-59999 will be reimbursed at 88% of the Medicare non-facility rate.

e. Payment for services billed by a Psychologist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or 74% of the Medicare non- facility based rate.

7. Home health care services:
   a. Intermittent or part-time nursing services provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.
   b. Intermittent or part-time nursing services when no HHA: lower of a) billed charge, or b) fixed fee per hour.
   c. Home health aide services provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.
   d. Equipment and appliances: retail charge less negotiated discount.
   e. Physical, occupational or speech therapy provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.
   f. Disposable supplies:
      1) If a supply item has a National Drug Code (NDC) number and is listed: lower of a) billed charge, or b) 90% of Average Wholesale Price (AWP) as indicated on the current listing provided by the First Data Bank plus a handling fee.
      2) If a supply does not have an NDC number, is not listed and Medicaid has established a published fixed fee: lower of a) billed charge, or b) fixed fee schedule.
      3) If a supply does not have an NDC number, is not listed and Medicaid has not established a published fixed fee: 70% of billed charge.
      4) Payments for disposable supplies for Medicare crossover clients will not exceed the upper limits at 42 CFR 447.304.
8. Private duty nursing services: lower of a) billed charges, or b) fixed fee schedule.

9. Special clinic services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy.
   a. Surgical codes 10000-58999 and 60000-69999 will be reimbursed at 69% of the Medicare facility rate
   b. Radiology codes 70000-79999 will be reimbursed at 100% of the Medicare facility rate
   c. Medicine codes 90000-99199 and 99500-99999 and Evaluation and Management codes 99201-99999 will be reimbursed at 60% of the Medicare non-facility rate.
   d. Anesthesia services will be reimbursed at a fixed fee per unit value of the 1974 CRVS as modified.
   e. Obstetrical services classified under CPT codes 59000-59999 will be reimbursed at 88% of the Medicare non-facility rate.

10. Dental services: lower of a) billed charge, or b) fixed fee per unit value for CDT codes. Services billed using CPT codes will be calculated using the April 1, 2002 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2002 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below
    a. Surgical codes 10000-58999 and 60000-69999 will be reimbursed at 100% of the Medicare facility rate.
    b. Radiology codes 70000-79999 will be reimbursed at 100% of the Medicare facility rate.
    c. Evaluation and Management codes 99201-99999 will be reimbursed at 85% of the Medicare non-facility rate.

11. Therapy
    a.. Physical therapy: lower of a) billed charge, or b) the 2002 Nevada specific, non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the 2002 Medicare Physician Fee Schedule conversion factor,

    b. Occupational therapy: lower of a) billed charge, or b) the 2002 Nevada specific, non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the Medicare Physician Fee Schedule conversion factor,

    c. Services for individuals with speech, hearing, and language disorders: lower of a) billed charge, or b) the 2002 Nevada specific, non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the 2002 Medicare Physician Fee Schedule conversion factor,

    d. Respiratory therapy: lower of a) billed charge, or b) the 2002 Nevada specific, non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the 2002 Medicare Physician Fee Schedule conversion factor,

24. Pediatric enhancement for recipients under the age of 21 will be calculated as follows:
    a. Surgical codes 10000-58999 and 60000-69999 will be the lesser of billed charges or 170% of the maximum allowable rate as described elsewhere in 4.19B for the code billed for the following services:
        1. Physician. See also 5.a.
        2. Advanced Practitioner of Nursing / Physician Assistant / Nurse Midwife / Nurse Anesthetist. See also 6.d.1.
        3. Podiatrist. See also 6.a.1.
        4. Optometrist. See also 6.b.
        5. Dental. See also 10.a.
        6. Special Clinics. See also 9.a.
        7. Early and Periodic Screening, Diagnostic and Treatment (EPSDT). See also 4.a.-b.
        8. Outpatient Hospital. See also 2.a.
    b. Radiology codes 70000-79999 will be the lesser of billed charges or 120% of the maximum allowable rate as described elsewhere in 4.19B for the code billed for the following services:
        1. Physician. See also 5.b.
        2. Podiatrist. See also 6.a.2.
        3. Optometrist. See also 6.b.
        4. Dental. See also 10.b.
        5. Special Clinics. See also 9.b.
        6. Early and Periodic Screening, Diagnostic and Treatment (EPSDT). See also 4.a.-b.
        7. Outpatient Hospital. See also 2.a.
    c. Medicine codes 90000-99199 and 99500-99999 will be the lesser of billed charges or 120% of the maximum allowable rate as described elsewhere in 4.19B for the code billed for the following services:
        1. Physician. See also 5.c.
        2. Advanced Practitioner of Nursing / Physician Assistant / Nurse Midwife / Nurse Anesthetist. See also 6.d.2.
        3. Podiatrist. See also 6.a.3.
        4. Optometrist. See also 6.b.
        5. Special Clinics. See also 9.c.
        6. Early and Periodic Screening, Diagnostic and Treatment (EPSDT). See also 4.a.-b.
        7. Outpatient Hospital. See also 2.a.

25. Newly developed Current Procedural Terminology (CPT) codes determined to be for Nevada Medicaid covered services: Codes will be entered into the system using the Nevada specific unit value developed by Medicare. The 2002 Medicare Physician Fee Schedule conversion factor will be used to calculate payment. The maximum allowable will be established by multiplying the unit value and the 2002 conversion factor and then paying the appropriate percentage based on the provider type, service type and CPT code range.

    If a code is billed that has no Nevada specific Medicare rate, the Division will determine if there is national Medicare pricing. If so, the service will be paid at the appropriate percentage of that rate. If there is no national Medicare pricing, the Division will establish pricing based on similar services.